The Editor's Note: The Social Life of Health, Illness, Medicine and Health Care: Anthropological Views

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"*We are all in the same frail boat.*"
— Gerald D. Berreman

On March 23, 2010, US President Barack Obama signed into law **The Patient Protection and Affordable Care Act, Public Law 111–148**. The brouhaha around health care reform had been brewing for years, and would not end the day the President signed PPACA into law, 906 pages of legislation passed by the US Congress. Some observers might argue the real battle had begun that day. Others would see it as déjà-vu all over again since two decades earlier, oppositional forces converged to defeat the 1993-1994 **Health Security Act**, the Clinton Health Care Plan. Indeed, efforts at **national healthcare reform** went back even further, by at least **seventy years**.

In the days following the **signing of the 2010 bill**, the latest **battle over health care reform** began to rage on Capitol Hill. The matter was even brought to and decided upon by the **Supreme Court**, and key requirements of the law were deemed constitutional. The federal government could move forward to implement the Reconciliation Act and the Affordable Care Act, requiring every American to have health insurance.

As the day grew closer for health insurance enrollment to begin, the battle became fierce, with a budget standoff rooted in the politics of health care reform that resulted in a (partial) **government shutdown** that lasted sixteen days in October 2013. The matter of reform proceeded, though quite slowly since the **federal website** on which applicants were to enroll, was a **mess**. Before long, things got a bit better—the website saw improvement, more people were able to enroll, and by the close of 2013, over **2 million Americans**, a small fraction of the uninsured, became owners of newly minted health insurance policies.

The whole mess—the fights, the threats, the web crashes—was successful in capturing the public's attention. Maybe it succeeded in distracting them too. What were the terms of the battle, and who set those terms? As one among the public, I found myself wondering about the discourse that has dominated the airwaves, talk shows, newspapers, and Internet: what is being left out, what is *silenced*? In times like this, I feel the need to step back, take a deep breath, and get some distance. I also know that anthropology can help with that. The discipline provides a way of looking at things from other angles, a necessary respite when the familiar becomes so intense, it blinds.

I set out to prepare this edition of *Open Anthropology* with a focus on the anthropology of health, illness, medicine, and health care for two reasons. First, the topic is certainly timely and fulfills the mission of ***Open Anthropology*** to bring the discipline into the public conversation about critical social issues and contemporary policy debates. Second, I offer a selection of articles that help defamiliarize the "normal," that make strange the familiar, a process that can lead to new insights, understandings, and positions. In the title of this edition, the phrase "the social life of" precedes the words "health," "illness," "medicine," and "health care." I chose this

phrase to capture the idea that each of these "things" is situated in a set of social relations and dynamics that are neither natural nor inevitable (anthropologists use the word "contingent" to capture the idea that everything has a history and a context), and that are understood by people in terms of ideas, beliefs, and the meanings people attach to them.

It is always a challenge to pick among the hundreds of thousands of pages in the **full AAA journal collection** to feature in any particular edition of *Open Anthropology*. There is so much rich material to choose from across time, subdiscipline, interests and affinities. The American Anthropological Association is comprised of over forty **sections and interest groups**, including **Society for Medical Anthropology** (SMA), which itself supports ten **interest groups**. Between section websites and the 20+ journals, there is an enormous amount of AAA information that can be accessed on a range of topics and issues.

The SMA website is a go-to place for information about medical anthropology and the anthropology of health, illness, medicine, and health care, the topic at hand. For example, SMA's **Critical Anthropology of Global Health Interest Group** has prepared a set of materials related to **health insurance reform**: 1) **U.S. Health Insurance Reform Bibliography**; 2) **Global Health Reform**; 3) **Index of country/topic specific statements on insurance reform**; and 4) a draft policy statement titled "**SMA 'Take a Stand' Statement: Health Insurance Reform**" produced in the wake of PPACA (an **updated "SMA 'Take a Stand' Statement" on ACA** appears in January 2014). According to the authors, "Take a Stand" is designed "to stimulate critical dialogue about how health care can be delivered both equitably and efficiently—in the United States and across the globe" (**Sarah Horton**, **César Abadía**, **Jessica Mulligan** and **Jennifer Jo Thompson**). The authors pose hard questions about what is assumed and what is really known about the US system of health care delivery and proposed reforms, and suggest that anthropological knowledge, information and comparative analyses offer powerful antidotes to the distractions of ubiquitous misinformation.

The compilation of 11 articles and three book reviews in this edition of *Open Anthropology* opens with an article from ***Medical Anthropology Quarterly***, SMA's peer-reviewed journal currently edited by **Clarence C. Gravlee** of the **University of Florida**. The article is co-authored by Barbara Rylko-Bauer and Paul Farmer, both high-profile medical anthropologists.

Rylko-Bauer is author most recently of the intimate ethnography, ***A Polish Doctor in the Nazi Camps: My Mother's Memories of Imprisonment, Immigration, and a Life Remade*** (Oklahoma University Press 2014). **Farmer** is the anthropologist-physician from **Harvard** who co-founded **Partners In Health (PIH)**, the global nonprofit that twenty-seven years ago began developing what is now a proven model of community-based treatment for the delivery of high-quality health care around the world.

Rylko-Bauer and Farmer published "Managed Care or Managed Inequality? A Call for Critiques of Market-Based Medicine" a dozen years ago, when PIH had already enjoyed 15 years of on-the-ground experience providing top-notch health care in resource-poor settings. In their review article, the authors summarize the state of health care delivery in the US on a number of indicators, including quality, cost, and the documented consequences of inequality in access to care on health outcomes. They put front and center what has been effectively removed from the discussion of health care reform then and health care reform now: the battles are "played out

against the largely unchallenged and expanding backdrop of *for-profit medicine*" (476, emphasis mine).

Rylko-Bauer and Farmer make explicit that the market principle guides direction of health care practice as well as health care policy reform. Health-care-as-commodity and medicine-as-commerce means profit gets priority and cost-effectiveness becomes a key mission. That health care is rooted in the marketplace helps explain why public discussion and policy proposals are generally framed in economic terms, "focusing on cost as the root of most problems" (477). Over the past three decades there has been a shift towards deeper corporatization and commodification of medicine. Medicine is not just business, it is big business, the authors argue, that "often denies it is a business" (485). I wonder if this denial is strategic, considering health care reform debates do not seriously question the market principle.

The authors of "Managed Care or Managed Inequality?" also document the relatively poor US performance on basic health indicators as compared to other countries, despite enormous spending levels (479-480). It seems medicine-as-business may be lucrative for some, but not adequately effective for the many.

We learn from Rylko-Bauer and Farmer that the problems of health care, illness, and medicine are problems of society. Health care disparities reflect and are an indicator of the larger social problem. The matter of the uninsured, the unstably insured and the underinsured is also a symptom of a system that is not well. When it comes to health care reform, a system rooted in the marketplace will inevitably lead to the kinds of cost-shifting strategies that are commonplace, where unfair burdens are placed on those without lobbyists to represent their interests.

Rylko-Bauer and Farmer offer an alternative principle, a way to cure the fragmentation of the US health care system. That principle is "health care as a right" (477), an ethical standard that has also guided Partners In Health to succeed in delivering quality health care where and when others could not. "Health care as a right" is rooted in principles of "justice and social good" (477) and "equity and social responsibility" (482). To reverse adverse outcomes of poor health care delivery and differential access to quality care, Barbara Rylko-Bauer and Paul Farmer conclude that medicine must be removed from the marketplace.

When Rylko-Bauer and Farmer suggest an alternative principle (one that does not currently guide US society's approach to medicine), they say so as *moralists*, and in Farmer's case, as a *physician* who has first-hand knowledge of what happens when a society chooses the market principle over the principle of the common good.

When Rylko-Bauer and Farmer talk about the market principle that currently guides US society's approach to medicine, they make the observation as *anthropologists*. They bring to the fore and make explicit what the public may "kind of" know but does not necessarily or fully recognize as a fundamental truth: any principle underlying the logic of a social world is subject to change. This is what anthropology does so well. It provides a way to stand outside our own world, question that which we may take for granted, look back at it with fresh eyes, and come to realize that the world as it exists is not the world as it might be.

The second and third articles in the collection bring us into classic anthropology, which is characterized by descriptive information and comparative analysis. In the case of this "dated" material, the author's ethnocentrism is revealed in the language that frames the information provided. The two pieces were published in ***American Anthropologist***, the flagship journal of the AAA currently edited by **Michael Chibnik**.

The twin articles are by **Erwin H. Ackerknecht**, an anthropologist and historian of medicine whose biographer describes his work as prescient: "Ackerknecht wrote on the social and ecological dimensions of disease…His emphases [were] on everyday medical practice and on siting ideas in their social and institutional context…a forerunner of contemporary trends in social and cultural history" (**Charles E. Rosenberg** 2007). Ackerknecht is author of ***A Short History of Medicine***, first published in 1955 (and still in print). His articles in our collection are titled "On the Collecting of Data Concerning Primitive Medicine" (1945) and "Primitive Surgery" (1947).

For the purposes of understanding the "social life" of medicine, Ackerknecht's comparative perspective offers insight through description of cross-cultural practices. "There is a great variety of ways of handling a sick person," observes Ackerknecht ("Collecting Data" 428), and adds, "these attitudes…are extremely revealing as to the general philosophy of a society…" (428), an assertion affirmed by Rylko-Bauer and Farmer. In "Primitive Surgery," Ackerknecht provides a catalogue of medicinal and surgical practices across time, place and cultures, including treating wounds (25-26), fixing fractures (27-28), and performing amputation (30), Caesarean section (32) and trepanation (skull surgery, 32-33), affirming his belief in the value of "matter of fact" observation. He applauds efforts of Europeans in the 16th-17th centuries to document indigenous medical practices in the "New World," such as those of **Francisco Hernandez** and **Willem Piso** who recorded the efficacy of certain practices, particularly the use of native and cultivated plants (ethnobotany). Ackerknecht also notes certain commonalities in medical practices and beliefs among European observers and indigenous healers. By the late 19th century, Ackerknecht asserts, differences between "modern" and indigenous medicine became entrenched in the minds of Western "medicine men" who believed manufactured medical technologies and remedies were *naturally* superior to any and all forms of indigenous medicine. Ackerknecht saw this as an unfortunate development, suggesting that "civilized" society blinds itself to new knowledge by its own prejudices, beliefs, and "the taboo set in our own society upon the study of specialties by outsiders" (427- 428).

Ackerknecht's biographer writes of his subject, "he was a vigorous advocate of a powerfully felt but, in retrospect, inconsistent relativism" (Rosenberg 2007:511). This assessment seems accurate; even a quick read of Ackerknecht's two articles in *American Anthropologist* reveals it.

The prejudices of Ackerknecht's times are transparent in the language he uses and in some of his observations. Use of words and phrases like "savages," "savage medicine," or "primitive" in comparison to "Western" and "civilized," or "witch doctor" and "wizard" versus "physician" and "surgeon" signals ethnocentrism, the belief in the superiority of one's own group. This reflects the "inconsistent relativism" to which his biographer refers.

Ackernecht is a cultural relativist to the degree he was able to document and assess medical and medicinal practices cross-culturally. He offers wise insight, teaching us, for example that

"disease and its treatment are not just more or less incidental traits; they are essential problems in the functioning of every society, in the life of every individual" ("Collecting Data" 430). However, some of his descriptions are suspect: *"…in Uganda the medicine-man first chops the limbs off as an executioner, to treat the wounds later as a surgeon*" is a vivid statement that is far from "matter of fact." The author does not situate the statement in any meaningful context ("Primitive Surgery" 36). Some conclusions are also suspect, as much for what is emphasized (magic and the supernatural) as for what is not (knowledge built on experience): "*It seems, therefore, that the most satisfactory explanation for the particular character of primitive surgery lies in the direction of the limiting influence which supernaturalistic ideas among primitives exert upon the development of the operator's art*" ("Primitive Surgery" 38).

It is difficult to see our own ethnocentrism. Contemporary anthropologists try to learn from the mistakes of the discipline's past. They work hard to confront their own assumptions and prejudices, an ongoing and imperfect process. The next reading helps get us towards that goal. "Body Ritual of the Nacirema" by **Horace Miner** is a true classic, published in *American Anthropologist* in 1956. "Nacirema" is probably the most widely circulated anthropology article, used as a primer in introductory courses in anthropology. Readers who know it, may find it fun to skim again. For those who do not, I guarantee a good laugh. All the same, Miner's concluding words are food for thought:

> Our review of the ritual life of the Nacirema has certainly shown them to be a magic-ridden people. It is hard to understand how they have managed to exist so long under the burdens which they have imposed upon themselves. But even such exotic customs as these take on real meaning when they are viewed with the insight provided by Malinowski when he wrote (1948:70): "Looking from far and above, from our high places of safety in the developed civilization, it is easy to see all the crudity and irrelevance of magic. But without its power and guidance early man could not have mastered his practical difficulties as he has done, nor could man have advanced to the higher stages of civilization."

The next article in our collection comes from the publication of **The Society for Anthropology in Community Colleges** (SACC), currently edited by **Lloyd Miller.** The Society publishes **Teaching Anthropology: SACC Notes**, an open-access publication dedicated to promoting excellence in teaching anthropology across the subdisciplines and in different kinds of educational institutions.

The short article by **Stephen Duray**, a professor at Palmer College of Chiropractic, focuses on teaching, offering instructors a review of the state of prehistoric health studies as it stood in 1996, nearly twenty years ago. In some ways, the article is highly technical, providing information on specific indicators of disease in skeletal remains. "Current Trends in the Study of Prehistoric Health" is included in our collection for what it reveals about social science approaches to the study of health (in this case, prehistoric health), and for the powerful myth about "progress" it debunks.

In terms of social science approaches to the study of prehistoric health—with implications for the study of contemporary health and illness, Duray notes "new trends" in paleopathology (the study of ancient disease) that considers biological, cultural, and historical factors (5). Among

the new trends noted by Duray (in 1996), were the impact of culture contact on health and the need to consider multiple indicators of biological stress (for an update see Alan Goodman's 2012 Presidential Address "**Bringing Culture into Human Biology and Biology Back into Anthropology**").

In terms of "myth busting," Duray explains what the evidence suggests: we may imagine the cultural adoption of agriculture (approximately 10-12,000 years ago) an obvious sign of human "progress," but paleopathology suggests we hold off on the judgments. Agriculture cannot be said to be superior or inferior to hunting and gathering since each subsistence strategy brings certain benefits and has its own costs, as Duray illustrates: compared to hunter-gatherers, "Farmers…suffered increased infection, malnutrition, metabolic stress and reduced longevity…agriculture allows more mouths to be fed than hunting and gathering, albeit at considerable cost…" (5; for updated information, see Alan Goodman's 1993 article "**On the Interpretation of Health from Skeletal Remains"** and Dorian Q. Fuller's 2010 article "**An Emerging Paradigm Shift in the Origins of Agriculture**").

In the vast sweep of geologic time, general patterns in the life history of humankind can be discerned (for example, the transition from hunting, gathering and fishing to agriculture economies). On closer inspection, and on a human time scale, the story reveals itself to be more deeply entangled than the generalities suggest. The situation (whatever it may be) can only be understood by uncovering the contingent factors that brought it into being.

This understanding is beautifully illustrated in archaeologist John Miksic's article set in ancient Indonesia. **Miksic**, a professor at the **National University of Singapore** looks to solve a puzzle in "Water, Urbanization, and Disease in Ancient Indonesia" an article that appeared in the 1999 volume of the ***Archeological Papers of the American Anthropological Association***, the journal of the **Archaeology Division** currently edited by **Lynne Goldstein**.

The puzzle is this: in the 14th century, how did people manage to build a city in **east Java**, a tropical zone where supporting and sustaining a dense urban population was so difficult?

Miksic answers the question step by step. We learn why early urbanization in tropical areas of the world is relatively rare (it's the water and the mosquitoes, 171). We learn that culture contact in the 17th century had disastrous effects (the Dutch canal system emphasized *stagnant water*, a breeding ground for disease-carrying insects, leading to disaster and human death, 173), and we learn how the people of **Trowulan**, now a **UNESCO World Heritage site**, solved the problem posed by urbanization in the tropical zone (they developed a complex hydraulic system for potable water, for flowing water, and for storing water, 177-179).

Miksic puts the pieces of the puzzle together, using archaeological, ecological, and cultural evidence. In a nuanced way, he fleshes out the multiple variables operating in a specific ecological and geopolitical location and at a particular historical time that together factor into real outcomes of wellness or sickness. This is the social life of health and illness.

At this juncture, I offer another kind of stepping back, a respite from the focus on the social life of health and illness, by including a powerful and moving article by Gerald Berreman who until

his **death** in late December 2013 was Professor Emeritus at the University of California, Berkeley.

Thirty-four years ago, Berreman wrote, "Are Human Rights Merely a Politicized Luxury in the World Today," though it could have been written yesterday. Berreman's words were prophetic and remain relevant.

The article appeared in the 1980 edition of ***Anthropology and Humanism Quarterly***, a publication of the **Society for Humanistic Anthropology** (SHA). The SHA journal is now called ***Anthropology and Humanism***, and is currently edited by **George Mentore**.

In my view, Berreman was the quintessential anthropologist—a humanist, a human rights advocate, a moralist, a scholar. For Berreman, "the quality of human life is what [he] take[s] to be the meaning of the phrase 'human rights'" (1); the article discusses the *relationship* between technology and the quality of human life. What can be said for that dynamic can also be said of the relationship between health care and the quality of human life, a matter of human rights.

"We are all in the same frail boat," are Berreman's words I drew from his article for the epigraph that begins this editorial (12). We are all vulnerable to the consequences of the kind of world we, as humans, have chosen to make. Berreman tells us there is nothing "inexorable or natural" (6) about what we have made. Should we decide to do so, we can retain or take down that which we have crafted.

And what we have crafted, in Berreman's view, has some very poor impacts on the quality of human life. If, as Berreman argues, "*the* major feature" of civilization is social inequality, then what is the motor behind that inequality? Berreman offers an answer and a caution: "The voracious pursuit of profit irrespective of human impact; the thoughtless, glib, and even disingenuous claims to social benefit where in fact there are none, where in fact dire social damage is more common, simply will not do in the world today unless one is willing to court disaster for all" (4).

We have a choice. Use the tools, the technology, the innovations for social betterment, for health, for well-being. Or not.

In a human-made world marked by social stratification (unequal access to resources) where "some live well and long, some live poorly and briefly" (7), a situation that has worsened enormously since 1980, there will be blowback. In his pre-9/11 essay, Berreman warns: "What I am suggesting is that international terrorism, street crime, guerilla warfare are all dependent variables in the equation of inequality, not the independent variables that many elites and governments seem to believe them to be. They are not controllable for long by police, armies, surveillance systems, deterrence and other tried and untrue formulae. They are controllable only by eliminating the root causes—poverty, oppression, want, envy—in short, inequality. They are a product of oppression and as the psychiatrists who authored *The Mark of Oppression,* wrote some 30 years ago: *'There is only one way that the products of oppression can be dissolved, and that is to stop the oppression'* (Kardiner and Ovesey, 1951:387)."

Berreman offers no room for plausible deniability in the broadest sense of the term: "By providing *forewarning of impacts*…policy-makers [are forced] to confront the probable consequences of their policies, depriving them of the widely-employed excuse: 'we did not know this would happen,' or the even more widely employed dodge of ignoring, obfuscating, finessing or simply denying the consequences of their acts" (5, emphasis mine).

It is no accident that Berreman saw the world the way he did. After all, he was an anthropologist, a discipline that "leads us to look at our own society with perhaps an unwontedly jaundiced eye, for we know ours to be only one of many ways of being human" (1).

Aspects of Berreman's argument are captured in the particulars of Thomas Leatherman's article, the next in our collection. **Leatherman** is Professor of Anthropology and Department Chair at the **University of Massachusetts, Amherst**. "A Space of Vulnerability in Poverty and Health: Political-Ecology and Biocultural Analysis" was published in 2005 in ***Ethos***, the journal of the **Society for Psychological Anthropology**, currently edited by **Edward D. Lowe**.

Leatherman's approach is comparative, which Berreman considers "the essential characteristic of science and the hallmark of anthropology" (1). It is also holistic. Though it's a mouthful to say, Leatherman summarizes his method as "a political-ecological approach for biocultural analyses that attempts to synthesize perspectives from anthropological political economy and those from ecological anthropology and human adaptability approaches" (46). He won't leave anything out.

Leatherman takes us to a place called **Nuñoa**, high up in the Peruvian Andes for answers to his most pressing of questions: "…why are some people poor in the first place, why do some get sick when others do not, and why are some able to cope with problems when others cannot?" (51). Inherent in Leatherman's questions is Berreman's charge for anthropologists to research and advise on the human impact of local and global planned change, of "development," of "progress"—to document and demonstrate the personal and social consequences for the people involved (Berreman 5). It is what Leatherman refers to as "a space of vulnerability" where "risks" can be identified, observed, documented, and addressed.

Berreman outlined the elements; Leatherman's case study contains them. "Poverty and Poor Health in Nuñoa" (53) is a cautionary tale involving poverty, hunger, disease, land, labor, habitat, adaptation, policy, stratification, and revolution. By giving focused attention to health and household economy in Nuñoa, Leatherman captures the most nuanced aspects of the situation—the specific grades of inequality, the degrees of vulnerability, the coping responses, and the multiple consequences that result.

Marcia Inhorn is author of the next article included in this collection. Inhorn is **Professor of Anthropology and International Affairs** at Yale University and author with Emily Wentzell of ***Medical Anthropology at the Intersections: Histories, Activisms, and Futures*** among many other publications. Her article in our collection is titled "Defining Women's Health: A Dozen Messages from More than 150 Ethnographies," which appeared in the 2006 edition of *Medical Anthropology Quarterly*.

Inhorn's article is a great resource for those interested in more deeply exploring the issues raised in this editorial. With a focus on women's health, Inhorn provides a large, though incomplete list of ethnographies, identifying key points made by anthropologists on the subject. She provides a huge service to readers by identifying and summarizing a dozen thematic messages in these 150+ works. Those themes range from "the cultural construction of women's bodies" (353) to "the power to define women's health" (348), "the increasing medicalization of women's lives" (354) and "the politics of women's health" (363).

As Inhorn notes, ethnography is a gift of the discipline of anthropology—it gives to the world a unique window into people's life experiences (346). The final articles in our collection take us to two very different locations where—by means of ethnography—we come away with "rich, if inherently subjective—understandings of [human] lives" (346).

Michele Rivkin-Fish brings us to hospitals and homes in post-Soviet Russia, a geo-political location and cultural space undergoing enormous transformation. Rivkin-Fish is Associate Professor of Anthropology at University of North Carolina at Chapel Hill and author of ***Women's Health in Post-Soviet Russia: The Politics of Intervention***, an ethnography that appears on Inhorn's list.

Rivkin-Fish's elegant 2009 article is titled "Tracing Landscapes of the Past in Class Subjectivity: Practices of Memory and Distinction in Marketizing Russia." It was published in ***American Ethnologist*** (AE), currently edited by **Angelique Haugerud**, the journal of the **American Ethnological Society** (AES).

In the course of conducting ethnographic research on Russian reproductive health reforms, Rivkin-Fish came upon a confusing and paradoxical find. The "find" was in comments people made, and the literature they adored (specifically, Mikhail Bulgakov's story "Heart of a Dog"). At a time when the country's social safety net was being dismantled, and social stratification began intensifying, some Russians seemed to embrace "stratified consumption in health care services" (80).

How could it be, Rivkin-Fish thought, that inequality could be understood as social progress, "a moral form of development" (80)? She wondered, "Why did midwives, themselves struggling with long-standing and unabated poverty, consider paying health care consumers to be morally superior to the 90 percent of patients who relied on free services (88-89)?"

Rivkin-Fish set out to find the answers. To get there required moving "outside the realm of health care into narrative landscapes of memory" (80), a fascinating journey she recounts in this article. The anthropologist discovers that "Market economics, with its severe upheavals and increasing vulnerability for the vast majority of Russians, has also spawned new desires and offered shifting images of the kinds of lifestyles that are possible," particularly for the intelligentsia, those "representatives of high culture" who under the Soviets had lost their privilege (80, 86). The intelligentsia and their descendants "remembered" what they had lost, seeing opportunity to reclaim it in the new, capitalist moment. I now wonder: will visions of the past (90) confront a disappointing future as Russian dreams of middle-class privilege get crushed?

The final article in our collection is by **Mitra Emad**, an anthropologist who is Associate Professor of Cultural Studies at the University of Minnesota, Duluth. Her article appears in ***Anthropology of Consciousness***, the journal of the **Society for the Anthropology of Consciousness**, currently edited by **Rebecca Lester** and **Peter Benson**.

Published in 2003, "Dreaming the Dark Side of the Body: Pain as Transformation in Three Ethnographic Cases," takes us into other dimensions in the social life of health, illness, medicine, and health care. Emad invokes three ethnographic cases, centered in the US, to reveal ways in which pain is itself a cultural construction. This does not mean that pain is a fantasy, but it does mean that humans understand, approach and even feel pain in ways that are dependent upon cultural understandings and meanings of pain, filtered through words and embodied sensibility. For Emad, understanding intractable pain as a "meaning-making enterprise" brings sufferers to an anthropological perspective that offers opportunity to engage, transform, and "take charge" of the very pain that debilitates them (23).

Three book reviews that appeared in recent issues of *Medical Anthropology Quarterly* round out this edition of *Open Anthropology*. The first is **Lenore Manderson's** review of Merrill Singer's ***Introduction to Syndemics: A Critical Systems Approach to Public and Community Health*. Singer** is among the most important voices in medical anthropology today. As Manderson notes in her review of this text, Singer initiated the biocultural and political economic concept of "syndemics" to capture the understanding that poor health is intimately linked with poverty and a lack of access to health care and that "diseases and disease sufferers do not exist in a vacuum and that many of the most damaging human epidemics are possible or probably consequence, not of a single disease acting alone but of several diseases acting in tandem" (**Singer, Bulled and Ostrach**). "Syndemics" has caught on, reflected in the fact that the term and the concept are now widely used in public health and medical literature. As many of the articles in this collection demonstrate, the observable facts captured by the single word are pervasive; the term provides a common language for talking about this complex phenomena.

The second is **Elise Andaya's** 2012 review essay of two books on the health care system in Cuba. According to Andaya (who has herself conducted fieldwork on health care in Havana), the volume by **Susan E. Mason**, **David L. Strug**, and **Joan Beder** on ***Community Health Care in Cuba*** is designed to "familiarize readers with Cuba's highly successful, integrated, and prevention-oriented health-care model through a detailed discussion of health-care delivery from the local to the national levels" (304). In ***Primary Health Care in Cuba: The Other Revolution*** by **Linda M. Whiteford** and **Laurence G. Branch**, the authors describe "the development of an extensive and world-class primary health model within an austere and authoritarian political system...underscoring the impressive successes of the Cuban public health care system [while] explicitly acknowledging…critiques of this model" (305).

The last review brings us back to Barbara Rylko-Bauer and Paul Farmer who—with Linda M. Whiteford published an edited volume titled ***Global Health in Times of Violence***. The 2011 review is by **Jean N. Scandlyn**, author with Sarah Hautzinger of the new ethnography ***Beyond Post-Traumatic Stress: Homefront Struggles with the Wars on Terror*** (2013).

Scandlyn describes *Global Health in Times of Violence* as "a truly comparative perspective [on the] relationship between violence and health, [exposing] the 'forces and networks' that shape

and sustain violence and often keep it hidden…" (299-300). Scandlyn closes her review with the poignant words of a war orphan child quoted by anthropologist **Carolyn Nordstrom** who contributed a chapter in *Global Health*: "'It's not just having heart—caring, not just thinking life. It's both. And then going on to give all this voice'" (301).

In their work, anthropologists gather many voices in hope these will be heard. In this essay, I have suggested that anthropological voices offer people a way to step back from what they think they know in order to see the world as if for the first time. There is value in that exercise. It may be uncomfortable, but it forces confrontation with complacency, and nurtures empathy and understanding—the very qualities needed to mend the frail boat.

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